



Medical Formula and Nutritionals Request Form



WIC Agency: _____

WIC ID#: _____

SECTION I: Participant/Patient and Health Care Information

Patient Name: (First) _____ (Last) _____		Date of Birth: _____
Parent/Caregiver Name: (First) _____ (Last) _____		Phone Number: _____
Height/Length: Current: _____ inches (Date: _____) Within 60 days At birth: _____ inches	Weight: Current: _____ lb _____ oz (Date: _____) Within 60 days At birth: _____ lb _____ oz	
Hemoglobin: _____ (gm/dL) or Hematocrit: _____ %	Lead Test: _____ mcg/dL	Lab Result Date: _____
Breastfeeding (birth to 12 months): <input type="checkbox"/> Fully breastfeeding <input type="checkbox"/> Feeding breastmilk & formula <input type="checkbox"/> Never breastfed <input type="checkbox"/> Discontinued breastfeeding on (Date: _____)		

To Health Care Providers: WIC **only** provides medically-necessary formula or medical food when they are **NOT** covered by Medi-Cal. Please refer patient to Medi-Cal for these products.

Patient's Health Insurance:

- ☐ **Medi-Cal** (Note: HCP must submit prior authorization (PA) to Medi-Cal Rx; then send PA and Rx to pharmacy)
- ☐ **Private** (does not cover enteral products)

SECTION II: Special Formula/Nutritionals and Qualifying Diagnosis

Formula/Medical Food Prescribed (Check below or specify name if not listed):

Premature: <input type="checkbox"/> Enfamil NeuroPro EnfaCare <input type="checkbox"/> Similac NeoSure Nutritional Drinks: <input type="checkbox"/> PediaSure <input type="checkbox"/> PediaSure with Fiber <input type="checkbox"/> PediaSure 1.5 Cal <input type="checkbox"/> PediaSure 1.5 Cal with Fiber Medical Formula: <input type="checkbox"/> Fortini <input type="checkbox"/> Similac PM 60/40	Hypo-Allergenic: <input type="checkbox"/> Alfamino Infant <input type="checkbox"/> Alfamino Junior, Unflavored <input type="checkbox"/> Alfamino Junior, Vanilla <input type="checkbox"/> EleCare Infant <input type="checkbox"/> EleCare Junior, Unflavored <input type="checkbox"/> EleCare Junior, Vanilla <input type="checkbox"/> Extensive HA <input type="checkbox"/> Neocate Infant <input type="checkbox"/> Neocate Junior, Unflavored	<input type="checkbox"/> Neocate Syneo Infant <input type="checkbox"/> Nutramigen (liquid concentrate; RTF) <input type="checkbox"/> Nutramigen LGG (powder) <input type="checkbox"/> Pepticate <input type="checkbox"/> PurAmino <input type="checkbox"/> PurAmino Junior <input type="checkbox"/> Similac Alimentum
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Form: (Check one) ☐ Powder ☐ Concentrate ☐ Ready-to-Feed (RTF) (Justification: _____)
 Required unless RTF is the only available form

Amount: _____ fluid ounces / ounces per day **Duration:** (Check one) ☐ 1 month ☐ 3 months ☐ 5 months
☐ 2 months ☐ 4 months ☐ 6 months

Qualifying Diagnosis: (Must specify)

<input type="checkbox"/> Prematurity (Adjusted age: _____ months)	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Low birthweight	<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Food allergy: _____	<input type="checkbox"/> Immune system disorder: _____		
<input type="checkbox"/> Gastrointestinal disorder: _____	<input type="checkbox"/> Life-threatening disorder: _____		
<input type="checkbox"/> Genetic/Metabolic disorder: _____	<input type="checkbox"/> Malabsorption (Nutrient: _____)		
<input type="checkbox"/> Other medical condition(s): _____			

SECTION III: WIC Food Restrictions

(Check one): ☐ **No food restrictions** (all WIC foods allowed) ☐ **Food restrictions** (specified below)

Infant
(6–11 Months): ☐ No infant cereal ☐ No infant fruits/vegetables ☐ No infant foods, increased formula
☐ If premature: Provide infant foods after _____ months

Children
(1–5 Years): ☐ No milk ☐ No cheese ☐ No eggs ☐ No yogurt ☐ No soy ☐ No tofu
☐ No peanut butter ☐ No beans ☐ No cereal ☐ No fruits/vegetables ☐ No juice
☐ No whole grains (Specify type(s): _____)
☐ Needs purees; provide infant fruits/vegetables ☐ No foods (formula only)

Comments:

SECTION IV: Health Care Provider Information

Provider Name (Printed): ☐ MD ☐ DO ☐ NP ☐ PA

Medical Office/Clinic Name and Address:

Provider Signature:

Date:

Phone Number:

Please Note:

WIC will not approve medical formula or medical food for the following conditions:

- Non-specific symptoms or diagnoses (e.g., colic, constipation, diarrhea, spitting up, picky eater, poor appetite, cramps, fussiness, gas, etc.)
- Solely to enhance nutrient intake or manage body weight without an underlying condition
- Non-specific formula intolerance or food intolerance
- Patient/caregiver preference or food dislikes

WIC qualifying medical diagnoses/conditions include but are not limited to:

- Severe food allergies that require an elemental formula
- Premature birth
- Low birth weight
- Failure to thrive
- Gastrointestinal disorders
- Malabsorption syndromes
- Immune system disorders
- Life threatening disorders
- Inborn errors of metabolism and metabolic disorders
- Diseases and medical conditions that impair ingestion, digestion, absorption or the utilization of nutrients that could adversely affect the participant's nutrition status

Visit www.wicworks.ca.gov; click *Health Care Providers* for more information on WIC Formulas.

Questions: Contact 1-800-852-5770 or Formula@cdph.ca.gov.